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Continuity of Care Maximizes Autonomy of the Elderly

Linda A. Hunt
Pacific University

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Continuity of Care Maximizes Autonomy of the Elderly

Description

If occupational therapy for an elderly patient is provided in only one setting for a short period, the therapist may not have the resources to repair diminished self-esteem and self-confidence, both of which the patient must have to achieve autonomy. Many elderly patients, once discharged from therapy, will retreat into their homes and will backslide because they lack a sense of purpose and a belief in their own effectiveness. A vicious cycle of decreasing ability and increasing dependence then begins (Kuypers & Bengston, 1973).

The following case report describes an occupational therapy program that provided continuity of patient care from a home care setting to a community setting. Patient care in the community setting was provided through a community wellness program. This program, by furnishing a supportive environment, made it possible to progress from the therapist saying to the patient, "You can do it," to a group of people saying to the patient, "You can do it," to the patient herself finally saying, "I can do it." The program therefore solved the problem of the patient's self-imposed isolation, enabling her to resume her place in the community.

Keywords

health services for the aged, Parkinson disease, therapy, community health services

Disciplines

Occupational Therapy

Comments

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CASE REPORT

Continuity of Care Maximizes Autonomy of the Elderly

Linda Hunt

Key Words: health services for the aged • Parkinson disease, therapy • community health services

Linda Hunt, OTR, is Program Coordinator in Geriatrics and Community Programs at the Irene Walter Johnson Institute of Rehabilitation, Washington University School of Medicine, 509 South Euclid, St. Louis, Missouri 63110.

Editor's Note. To continue the Case Report department, we need and welcome reports that document the practice of occupational therapy for specific clinical situations. Guidelines for writing case reports are available from the Editor.

If occupational therapy for an elderly patient is provided in only one setting for a short period, the therapist may not have the resources to repair diminished self-esteem and self-confidence, both of which the patient must have to achieve autonomy. Many elderly patients, once discharged from therapy, will retreat into their homes and will backslide because they lack a sense of purpose and a belief in their own effectiveness. A vicious cycle of decreasing ability and increasing dependence then begins (Kuypers & Bengston, 1973).

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Background

A 71-year-old woman with a history of Parkinson's disease since 1976 sought medical attention from a neurologist when her symptoms got worse in March 1985. Her past medical history included a right shoulder fracture and pinning in 1979, and a total knee replacement in 1980. Depression had been a chronic problem since the onset of the Parkinson's disease. At the time of her evaluation, her medications included Sinemet, Motrin, Inderal, Benadryl, and Thorazine.

After the evaluation, the neurologist decided that the patient would be best served in a home care setting for therapy. She was referred to occupational therapy to improve independence and activities of daily living, and to physical therapy for gait and transfer training (a home exercise program) and to determine what type of device to assist ambulation would be appropriate for her. The patient had never received therapy prior to this time.

Summary Evaluations of the Rehabilitation Team

Neurologist's Findings

The patient's mental status was alert, oriented, and cooperative. Her speech showed a mild dysarthria, and she spoke in a low-volume monotone. Cranial nerve examinations II through XII were intact with the exception of moderate, masklike facies and slight left facial weakness as a residual of a previous attack of Bell's palsy. Sensory modalities were intact to pin-

prick, proprioception, and double simultaneous stimulation. Motor examination showed normal strength and tone. However, the fracture had caused a decreased range of motion in the right shoulder. Movement from finger to nose was performed without significant ataxia or tremor. There was no spontaneous tremor at rest. There was moderate bradykinesia in both upper extremities, a moderate flexor posture, and decreased arm swing.

Physical Therapist's Findings

The patient required assistance to roll from side to side in bed, and a moderate assist to come to a sitting position from lying supine. Transfers were independent from armchair to standing, but slow. Difficulty was noted in walking, especially when turning.

Occupational Therapist's Findings

Through an interview and a demonstration the occupational therapy evaluation provided the following profile of the patient. She was a housewife living with her retired spouse in a small, two-bedroom home. They had an adult son who was married and had two children; family visits were about 2 to 3 weeks apart. Prior to the onset of parkinsonism, the patient had been independent in self-care, home management, and community activities of daily living such as shopping, visiting friends, and going to a restaurant. Her independence diminished in all these areas as her illness progressed.

During the initial occupational therapy visit, the patient would look at boxes of Christmas ornaments she had made and talk about former activities. "I made this blouse and those curtains hanging in the kitchen. Now my hands move slowly and awkwardly, making it difficult to mend clothes, and my eyesight is affected so I make mistakes." The patient rarely left the house for fear of a freezing spell: a sudden momentary inability to move. She and her husband had talked in the past of buying lakefront property when he retired because they both loved to fish, but they had recently decided against it. They were afraid to move away from the medical community.

As a consequence of her deteriorating physical condition, the patient had periods of depression. Her husband confided that he did all the shopping and errands, saying that his wife hadn't been out of the house in the last 4 months except to go to the doctor.

The occupational therapy evaluation revealed many deficits in daily living skills performance. Because of decreased range of motion in her right upper extremity, the patient had difficulty in bathing (she could not reach all parts of her body), in grooming (she could not comb her hair), and in upper extremity dressing.

Psychological and emotional daily skills were also found to be impaired. Because the patient could no longer engage in activities she valued and enjoyed such as sewing and handicrafts, her means of self-expression and, consequently, her image of herself as a competent person had deteriorated.

The patient also lacked adaptive skills for situational coping. She responded to her illness by decreasing her social contacts. For example, prior to her increased disabilities, she had been active in a women's church group, but she dropped out when she felt she could no longer contribute to the group. She felt that her speech was so affected that she could not be clearly understood. The deterioration of her speech caused both spouse and patient to retreat so that they became isolated and homebound.

Chronic disease negatively influenced the patient's interactions with her environment, causing her to feel that she had lost control over it. When patients feel they have no control over their environment, they begin to feel helpless. This helplessness leads to decreased motivation and, sometimes, decreased self-esteem (Teitelman, 1982).

Intervention

The occupational therapist's treatment plan consisted of using activities as a basis for increasing functional independence. Because of the patient's physical limitations, it was necessary to use a variety of specially adapted equipment to reach a level of competence and confidence. The patient accepted many personal aids such as a rocker knife, a long-handled sponge for bathing, and a reacher for lifting items from the floor as well as beyond her right-shoulder range of motion. These aids made it possible for her to regain greater independence. An example of her enthusiasm to return to avocational activities was her switch from needlepoint, which she could no longer do, to quickpoint, which she was able to conquer using a needle threader. After 4 weeks of therapy consisting of 2 hourly visits per week, she had improved enough to be able to make Christmas projects for her grandchildren.

Discharge Planning

After 2 months of home care, the home care rehabilitation team had successfully addressed the patient's physical problems through medication and exercises to improve mobility. They had also increased her self-esteem by increasing her independence in activities of daily living. The occupational therapist improved the patient's self-concept by working with her on her avocational interests—her craft talents. These talents had linked her to family and community. Emphasis in therapy now shifted from the efforts of the

home care team to reintegrating the patient and her husband into the community by increasing their participation in community activities of daily living.

Community-Based Program

Because the rehabilitation team no longer considered the patient homebound, Medicare guidelines required that she be discharged from home care therapy. To increase her participation in community activities of daily living the patient was referred to the Parkinson's Wellness Program, a program of 15–20 patients that met for 2 hours 2 days a week at a community facility. The program consisted of a segment on mat exercises, a segment on walking, a break for socializing, and a segment devoted to a group activity such as volleyball. Unfortunately, the program was not covered by medical insurance, but the patient agreed to pay for it.

In the beginning, the patient attended the program in a wheelchair. Her husband would hover over her, assisting her with all exercises, transfers, and activities. Gradually, the occupational therapist convinced the husband to allow the patient to exercise alone, aided only by the therapist when necessary.

The husband started to socialize with other spouses during the time that his wife was exercising. This socializing gave him topics of conversation to share with her during the ride home, and she, in turn, would report to him on her progress in the exercise program. The patient did not appear self-conscious about her own speech problems because most people in the group also had speech difficulties. Verbalizing became easier for her. Soon, the couple was making stops at the grocery store on the way home from the wellness program, or at the dime store to pick up some items for the patient to sew.

After 1 month, the patient stopped coming to the program in her wheelchair. She felt secure enough to use a walker and the standby assistance of her husband. After 6 months, the patient dropped out of the program because it was relocated further from her home. As this study was completed, she continued to get out of her house at least once a week to do errands with her husband.

Discussion

The community wellness program was instrumental in getting the patient and her husband out of their home and back into the community. Because the home care therapist also codirected the Parkinson's Wellness Program, the optimum degree of continuity of care and follow-up was achieved. Patient, spouse, and therapist felt that the patient had reached the ultimate occupational therapy goal: reintegration into the community.

This goal derives from a major sociological theory of aging, the continuity theory. This theory assumes that identity is a function of relations and interactions with other people. People who age most gracefully continue to maintain interaction with society after retirement, involving themselves in appropriate community, family, and interpersonal relationships. They continue to maintain both their identity and their self-esteem (Neugarten, 1973).

The elderly who are chronically ill often do not have the resources or skills to remain active and involved in everyday life. As this case report has shown, this population can be helped through continuity of care and reintegration into the community via wellness programs. Health-promoting activities can minimize the effects of a chronic disease and even reverse its progression. In fact, offering them the information, resources, and programs to encourage preventive healthcare and promote self-reliance can help not only the chronically ill but all older adults maintain their present level of health or achieve the level of wellness crucial to maintaining independence and an active life-style.

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